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January 19, 2004

Carol Duncan Clayton, Ph.D., Executive Director
NC Council of Community MH/DD/SA Programs
1318 Dale Street, Suite 120
Raleigh, NC 27605

Dear Ms. Clayton:

Enclosed are the Division of Mental Health, Developmental Disabilities and Substance Abuse Services' responses to the request for technical assistance on the Service Records Manual (APS-M 45-2, September 1, 2003) submitted by the North Carolina Council of Community MH/DD/SA Programs on October 6, 2003.

Please feel free to contact Marilyn Godette at 919-420-7934 or Marilyn.Godette@ncmail.net if we can be of further assistance in this matter.

Sincerely,

Darlene Steele
Regulatory Team Leader

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Responses to
Questions on the Service Records Manual
NC Council of Community Programs

1. Do we still have to re-write a CTSP plan every year or just review by target dates?

   Response: In accordance with the APS-M 45-2, 9/1/2003, page 12, under Review/Rewrite, it states:

   "At a minimum the service plan shall be reviewed by the responsible professional based upon the target date assigned to each goal, whenever the consumer's needs change, or when a service provider changes."

2. For documentation purposes for social inclusion, would it be considered under case management or should it be a regular service note?

   Response: In accordance with the APS-M 45-2, 9/1/2003, a service note is required. The documentation requirements can be found on pages 16, 17 and 18 of the APS-M 45-2, 9/1/2003. On page 16, it states that when a periodic service is provided, a service note that reflects the elements noted below shall be documented at least daily per service by the individual who provided the service. The requirements for the contents of a service note are as follows:

   Service notes shall include, but not be limited to, the following:
   1. **full date the service provided (month/day/year);**
   2. **duration of service for periodic and day/night services;**
   3. **purpose of the contact as it relates to a goal in the service plan;**
   4. **description of the intervention/activity;**
   5. **assessment of consumer's progress toward goals;**
   6. **for professionals, signature and credentials, degree, or licensure of the clinician who provided the service; and**
   7. **for paraprofessionals, signature and position of the individual who provided the service**

3. At what age can a child consent for treatment?

   Response: In accordance with the rules for Mental Health, Developmental Disabilities and Substance Abuse Facilities and Services (APS-M 30-1, 7/1/2003) a minor is defined as "a person under age 18 years of age who has not been married or who has not been emancipated by decree issued by a court of competent jurisdiction or is not a member of the armed forces" (10NCAC 27G .0103).

When the phrase "consumer/legally responsible person" is used and the consumer is a minor or an incompetent adult, the signing of the service plan shall be signed by the legally responsible person.

Exceptions are as follows:

a. **Per G.S. 90-21.5 (see Appendix B), if the minor is receiving mental health services as allowed in this provision, the minor's signature on the service plan is sufficient. However, once the legally responsible person becomes involved, the legally responsible person shall also sign the plan.**

   For minors receiving outpatient substance abuse services, the plan shall include both the staff and the child or adolescent's signatures demonstrating the involvement of all parties in the development of the plan and the child or adolescent's consent/agreement to the plan. Consistent with North Carolina law (G.S. 90-21.5), the plan may be implemented without parental consent when services are provided under the direction and supervision of a physician. When services are not provided under the direction and supervision of a physician, the plan shall also require the signature of the parent or guardian of the child or adolescent demonstrating the involvement of the parent or guardian in the development of the plan and the parent's or guardian's consent/agreement to the plan.

b. **For an emergency admission to a 24-hour facility, per G.S. 122C-223(a), "in an emergency situation when the legally responsible person does not appear with the minor to apply for admission, a minor who is mentally ill or a substance abuser and in need of treatment may be admitted to a 24-hour facility upon his own application." In this case, the minor's signature on the service plan would be sufficient.**

c. **For an emergency admission to a 24-hour facility, per G.S. 122C-223(b), "within 24 hours of admission, the facility shall notify the legally responsible person of the admission unless notification is impossible due to an inability to identify, to locate, or to contact him after all reasonable means to establish contact have been attempted." Once contacted, the legally responsible person is required to sign the plan.**

d. **For an emergency admission to a 24-hour facility, per G.S. 122C-223(c), "If the legally responsible person cannot be located within 72 hours of admission, the responsible professional shall initiate proceedings for juvenile protective services." In this case, the individual designated from juvenile protective services shall sign the plan.**

   Note*:* For minors receiving substance abuse services as a non-emergency admission to a 24-hour facility, both the legally responsible person and the minor are required to sign the service plan.

   On page 41 of the APS-M 45-2 (9/1/ 2003), it states that:

   1. Any minor may give effective consent to a physician licensed to practice medicine in North Carolina for medical health services for the prevention,

diagnosis and treatment of (i) venereal disease and other diseases reportable under G.S. 130-135, (ii) pregnancy, (iii) abuse of controlled substances or alcohol, and (iv) emotional disturbance. This section does not authorize the inducing of an abortion, performance of a sterilization operation, or admission to a 24-hour facility licensed under Article 2 of Chapter 122C of the General Statutes except as provided in G.S. 122C-222. This section does not prohibit the admission of a minor to a treatment facility upon his own written application in an emergency situation as authorized by G.S. 122C-222.
2. Any minor who is emancipated may consent to any medical treatment, dental and health services for himself or for his child.

Also see APS-M 95-2, 10A NCAC 27D.0303, Informed Consent and G.S. 130-135.

4. Twenty-four (24) working hours – is that 3 days if 8 hour day or next working day?

   Response: The reference to "24 working hours" is found in the APS-M 45-2 on page 18 under "additional requirements". It refers to the next working day.

5. Should PH service plan target date be for 12 months?

   Response: In accordance with the APS-M 45-2, page 11, it states that a target date shall not exceed 12 months. The Division of MH/DD/SAS discourages automatic target dates. Target dates should reflect the short-term nature of Partial Hospitalization.

   On page 12 of the APS-M 45-2, under Review/Rewrite it states, "At a minimum the service plan shall be reviewed by the responsible professional based upon the target date assigned to each goal, whenever the consumer's needs change, or when a service provider changes.

6. If client has an opened treatment record and is also seen in PH but is discharged from PH and later discharged, is a new Service Order needed?

   Response: In accordance with the APS-M 45-2, 9/1/2003, yes, a Service Order is needed. Refer to APS-M 45-2 (9/1/ 2003), page 7 which states:

   "All MH/DD/SA services reimbursed with Medicaid monies shall be ordered prior to or on the day the service is provided by the appropriate professional as defined in the Medicaid manual and DMH/DD/SA/ Service definitions. "

7. Can grid be used for SA prevention?

Response: In accordance with the APS-M 45-2, 9/1/2003, yes. There is a Service Grid described on page 44 of the APS-M 45-2, 9/1/2003 that is used for Substance Abuse Prevention.

8. Is there a difference between the grid and the service grid (indicated in appendix C for SA Prevention?

Response: In accordance with the APS-M 45-2, 9/1/2003, yes, there is a difference in the elements to be included. The Grid on page 17 of APS-M 45-2 (9/1/ 2003) may only be used for Day Habilitation, Supported Living, Supported Employment (CAP-MR/DD), Residential Treatment (Level I) and Residential Treatment-Family Type (Level II).

It must include the following elements:

a. **the full date the service was provided (month/day/year);**
b. **the goals that are being addressed;**
c. **a number or letter as specified in the key which reflects the intervention/activity;**
d. **a number or letter as specified in the key which reflects the assessment of the consumer's progress toward goals; and**
e. **Initials of the individual providing the service. The initials shall correspond to a signature on the signature log section of the grid.**

The Service Grid used for Substance Abuse Services for Child and Adolescent Prevention Services must be developed and contain the required elements found on page 44 of the APS-M45-2 (9/1/ 2003) which are:

1. A notation following the delivery of each service and shall include the date and duration of the service that was provided;
2. A listing of the individual child or adolescent and/or his or her family members that were in attendance;
3. An identification of the evidence-based program module and service type;
4. Session goal;
5. Standard activity description; and
6. The initials of the staff providing the service.

The initials shall correspond to a signature with credentials identified on the signature log section of the service grid.

9. Who is responsible for developing a "key" for the grid?

Response: In accordance with the APS-M 45-2, 9/1/2003, individual service providers and their supervisors with client input are responsible for developing their own key.

10. What are the documentation requirements for Social Inclusion?

Response: In accordance with the APS-M 45-2, 9/1/2003, page 16, it states that when a periodic service is provided, a service note that reflects the elements noted below shall be documented at least daily per service by the individual who provided the service. The requirements for the contents of a service note are as follows:

Service notes shall include, but not be limited to, the following:

1. **full date the service provided (month/day/year);**
2. **duration of service for periodic and day/night services;**
3. **purpose of the contact as it relates to a goal in the service plan;**
4. **description of the intervention/activity;**
5. **assessment of consumer's progress toward goals;**
6. **for professionals, signature and credentials, degree, or licensure of the clinician who provided the service; and**
7. **for paraprofessionals, signature and position of the individual who provided the service**

11. Should Service Note E be utilized for CBS and can revisions be made for only one block per page?

Response: In accordance with the APS-M 45-2, 9/1/2003, service note E may be utilized so long as all required elements are included. As stated in the APS-M 45-2, 9/1/2003 (page 5), all providers of MH/DD/SA Services in North Carolina may develop forms, which reflect the required elements as specified in this manual or chose to utilize DMH/DD/SAS sample forms.

Revisions (corrections) are not limited to one block per page and may be made as needed on service note E, but must follow procedures noted on page 20 & 21 of the Service Records Manual.

12. Are paraprofessionals held accountable for the assessment and how they write the assessment?

Response: Assessment means a procedure for determining the nature and extent of the need for which the individual is seeking service (APS-M 30-1(7-1-2003). A clinician or paraprofessional who has met the competency requirements within their scope of practice to conduct assessments may conduct it.

13. What is the requirement for documentation from Group Living?

Response: In accordance with the APS-M 45-2, 9/1/03, page 16, under contents of a service note, are found the documentation requirements for Group living. For

Group Living, also note the frequency requirements on page 17 under 24 Hour where other requirements are identified. The requirements are as follows:

Service notes shall include, but not be limited to, the following:

1. **full date the service provided (month/day/year);**
2. **duration of service for periodic and day/night services;**
3. **purpose of the contact as it relates to a goal in the service plan;**
4. **description of the intervention/activity;**
5. **assessment of consumer's progress toward goals;**
6. **for professionals, signature and credentials, degree, or licensure of the clinician who provided the service; and**
7. **for paraprofessionals, signature and position of the individual who provided the service**

The Following 24-Hour services shall be documented as follows:

Group Living, Family Living, Supervised Living-monthly or duration of stay if less than a month;

14. Is there a hold harmless period with the new manual?

    Response: In accordance with the APS-M 45-2, 9/1/2003, no, the requirements of the manual take effect 9/1/03.

15. Can CAP personal care and respite use the grid or do they have to use a narrative?

    Response: In accordance with the APS-M 45-2, 9/1/2003 (page 17), the grid may only be used for Day Habilitation, Supported living, Supported employment (CAP-MR/DD), Residential Treatment (Level I), and Residential Treatment-Family Type (Level II). The requirements for a service note can be found from page 16 to 19 of the APS-M 45-2, 9/1/2003.

16. Should CAP providers use the grid in the back of the manual or the one they were already using prior to 9/1/03?

    Response: In accordance with the APS-M 45-2, 9/1/2003 (page 17), the grid may only be used for Day Habilitation, Supported living, Supported employment (CAP-MR/DD), Residential Treatment (Level I), and Residential Treatment-Family Type (Level II). In addition, as stated in the APS-M 45-2, 9/1/2003 (page 5), all providers of MH/DD/SA Services in North Carolina may develop forms, which reflect the required elements as specified in this manual or chose to utilize DMH/DD/SAS sample forms.

17. Who determines the progress toward the goal?

Response: In accordance with the APS-M 45-2, 9/1/2003, the consumer, legal guardian, qualified professional and provider should determine progress together.

18. Can the case management log be used by other staff to record case support and assertive outreach activities?

    Response: Yes, in accordance with the APS-M 45-2, 9/1/2003 (page 5), all providers of MH/DD/SA Services in North Carolina may develop forms, which reflect the required elements as specified in this manual or chose to utilize DMH/DD/SAS sample forms.

19. Under medications and requirements for facilities, would a workshop who administers one dose of medication for a community individual living at home be required to obtain a 6-month medication review/assessment from the client's doctor or pharmacist? Ref: APS-M 45-2, ch. IX, page 25

    Response: In accordance with the APS-M 45-2, 9/1/2003, page 25, (and the APS-M 30-1, (01/01/2001)(10/01/02), page 20) if the consumer receives psychotropic drugs, a pharmacist or physician shall review the consumer's drug regimen at least every six months. The findings of the review shall be recorded in the consumer's record along with corrective action, if applicable.

20. Under medications and requirements for facilities, would a workshop who administers one dose of medication for a group home client be required to obtain a 6-month medication review/assessment from the client's doctor or pharmacist? Ref: APS-M 45-2, ch. IX, page 25

    Response: In accordance with the APS-M 45-2, 9/1/2003, page 25, (and the APS-M 30-1, (01/01/2001)(10/01/02), page 20) if the consumer receives psychotropic drugs, a pharmacist or physician shall review the consumer's drug regimen at least every six months. The findings of the review shall be recorded in the consumer's record along with corrective action, if applicable.

21. Can providers continue to use the current CAP forms for Personal Care and Respite in lieu of creating a new form?

RESPONSE: Yes, providers may continue to use the current CAP forms for Personal Care and Respite in lieu of creating a new form. Providers are not required to use the current CAP forms for Personal Care and Respite.

22. Are the requirements in the manual still effective? There are small differences such as signatures being required for PC in the manual but not the Service Record.

Response: In accordance with the APS-M 45-2, 9/1/2003, follow the APS-M 45-2 for signature requirements. Initials may be used if the full signature is included on the page.

23. Do providers need to begin using the new forms 9/1 or is there a grace period? Many have just found out about this the first week in August and are concerned about having the time to implement the change with staff.

Response: In accordance with the APS-M 45-2, 9/1/2003, providers need to begin using the new forms on 9/1/03. No, there is not a grace period.

24. Can providers continue to use the current grid for CAP services?

Response: In accordance with the APS-M 45-2, 9/1/2003, no, they cannot continue to use the old grid for CAP-MR/DD Services. The new grid requirements will be utilized. Please refer to the Service Records Manual: Major Revisions Contained In The Revised Service Records Manual with Memorandum from Richard Visingardi, Ph.D. dated July 12, 2003 (sent to all Area Program Directors). See: Grid (Chapter VI): The grid as specified in this chapter may ONLY be used for the following services: Day Habilitation, Supported Living, Supported Employment (CAP-MR/DD), Residential Treatment Level I, and Residential Treatment-Family Type (Level II).

25. If they can continue with the old grid will they have to add an A to the grid?

Response: In accordance with the APS-M 45-2, 9/1/2003, they cannot continue to use the old grid effective 9/1/03.

26. I do not see CBS listed in the documentation section as to what is required. In the draft manual it was listed with the grid but now it is not but the log is not listed either. Can you please clarify this for me?

Response: In accordance with the APS-M 45-2, 9/1/2003, CBS requires a regular service note. Effective September1, contact logs will no longer be allowed. Regarding the grid, we were not able to receive approval from DMA for CBS to use a grid. A "contact log" is like Contact Log A and Contact Log B in the 1998 Service Records Manual. A contact log did not require the effectiveness of the intervention to be addressed. Effective Sept 1 with the revised Service Records Manual, the effectiveness has to be addressed. However, if you have been using Service Note E, you have not been using a contact log but a full note. You can still chose one of the service note examples in the revised Service Records Manual.

27. Where can I locate information/requirements on what constitutes an appropriate step down plan?

Response: The requirement for step down plans is included in the CBS Definition. Step down plans are to be developed between the

consumer/legally responsible person and the provider. The appropriateness of the step down plan is based on the consumer's level of care needs.

28. How will DWI, Prevention, etc. change things locally now that a new plan does not have to be done annually?

Response: In accordance with the APS-M 45-2, page 12, provisions are established to allow for plans to be revised and reviewed. Local providers are to develop a systematic method of reviewing the quality, appropriateness and comprehensiveness of the service plan and a process for initiating plan revisions based on the results of such reviews. At a minimum, the service plan shall be reviewed by the responsible professional based upon the target date assigned to each goal, whenever the consumer's needs change, or when a service provider changes.

29. What distinguishes an authorization from a service order in the sense of documentation?

The difference between the service order and the authorization is that the service order may include a verbal or written order from the physician or Ph.D. psychologist, which establishes medical necessity. The authorization is the process which gives permission for the services to be provided, including the level of care and the amount and frequency of service provision.

30. Is it possible for there to be a modified record for the DWI client?

Response: In accordance with the APS-M 45-2, 9/1/2003, if the consumer is receiving treatment, documentation for DWI clients referred to ADETS must follow guidelines documented in the APS-M 45-2 (9/1/03) Chapter XII, page 32. All other levels of care documentation for DWI services must meet requirements outlined in Service Records Manual APS-M 45-2.

31. Is it sufficient for the clinician to write their signature and have the credentials, degree, and or licensure typed below the signature or must the clinician write it out? Page 16 of the new manual indicates that service notes shall include, but not be limited to: #6 "for professionals, signature and credentials, degree, or licensure of the clinician who provided the service". Further, can the Professional sign credentials OR degree OR licensure?

Response: In accordance with the APS-M 45-2, 9/1/2003, the signature must be written out. The APS-M 45-2, page 22, under the section titled Signature and Countersignatures states the following:

All entries in the service record shall be signed. For professionals, the staff member who provided the service and recorded the event shall sign their

name and credentials, degree, or licensure

32. Is a Goal # or Goal Statement required on the Case Management Activity Log or CM note?

Response: No, in accordance with the APS-M 45-2, 9/1/03, page 16, under the heading: Case Management Service notes, a goal # or goal statement is not required on the Case management Log or CM note. Also see the sample case management activity log in the APS-M 45-2, 9/1/03, appendix D.

Case management service notes shall include the following:

1. **date of service provided.**
2. **type of activity**
3. **location where case management services provided**
4. **brief description of the activity and outcome**
5. **Total time**
6. **Signature and credentials, degree or licensure of the case manger**

33. On the Service Plan, is duration interchangeable with the frequency OR must we include both elements?

Response: In accordance with the APS-M 45-2, 9/1/2003, the Service Plan requires both elements. On page 11 of the APS-M 45-2, 9/1/2003, the contents of the individualized service plan are listed below:

An individualized service plan is comprehensive plan that includes:

1. **Services goal(s);**
2. **Specific service modalities/interventions with frequency and duration;**
3. **Responsibilities of each member of the treatment/habilitation team;**
4. **a target date that reflects the timeframe within which the goal(s), modalities/interventions and frequency/duration and responsibilities of each member of the treatment/habilitation team will be reviewed. A target date shall not exceed 12 months.**
5. **Signature of staff and consumer/legally responsible person**

34. Does the CAP PLAN OF CARE require duration?

Response: No, please refer to the CAP-MR/DD Manual(2001): http://www.dhhs.state.nc.us/mhddsas/developmentaldisabilities/CAP Manual complete.pdf
Reference Appendix E, page E-1 for the Plan Of Care (POC). The POC requires service and frequency for outcomes but does not require duration.

35. It is understood that for the Annual Review the consumer's/legal guardian and clinician's signature and date is required whether the plan is revised or not. Does the above statement mean that for target/review dates that the consumer's/legal guardian's and the clinician's signature is needed whether or not there are revisions to the service plan? There has been some discussion that if there are no changes at the time of the review/target date that only the clinician's signature is required. However, the above statement seems to indicate that the consumer/legal guardian and the clinician's is required for review dates.

    Response: The plan of care must be revised annually (known as Annual Plan of Care Update or Continued Need Review) by the case manager (and treatment team). Reference the CAP-MR/DD Manual, Section 12, and page 12.1. In the rare case that there are no revisions to the plan, the Case Manager, Consumer and/or Legally Responsible person must sign and date the plan in the "For CAP-MR/DD Funded Consumers Only" section on page E-7 (Appendix E, CAP-MR/DD Manual).

    The clinician's signature is not required. The clinician's signature confirms the involvement in the development of the Annual Plan of Care Update, but the clinicians' signature is not required. Refer to the CAP-MR/DD Manual, Section 13, sub-section 13.5, page 13-5.

36. Page 17 of the service records manual addresses the frequency of service notes for 24-hour facilities/services with 6 items, 2 of which are: #4 Group Living, Family Living, Supervised Living – monthly (note) or duration of stay if less than a month. #5 Residential Treatment/Rehabilitation for Individuals with Substance Abuse Disorders – per shift (note).
    It's not clear as to whether a provider would fall into #4 or #5 category with the following specifics: This area program purchases Group Living Low substance abuse services from an agency that is licensed as .4300 Supervised Therapeutic Community. Their service is an Aftercare program, similar to a halfway house. Consumers participate in a training program for several months (Food and Beverage, Property Maintenance, Commercial Laundry, Horticulture) to prepare for employment. After 3 months or so, they are encouraged to obtain outside employment. They are assigned to a sponsor and must attend lectures/meetings, etc.

    They are currently documenting per month because the service is Group Living Low. Is this correct despite their licensing type?

    Response: In accordance with the APS-M 45-2, 9/1/2003, yes. This is the correct documentation frequency based on the APS-M 45-2, page 17, 24 hour-Frequency of a Service Note, which states "Group Living, Family Living, Supervised Living-monthly or duration of stay if less than a month.

37. Could a paraprofessional assign a primary diagnosis in BCMS based on the admission template used by Detox and the Professional staff counter-attest within AMH (Detox) policy guidelines?

Response: A paraprofessional is defined as a person with:

A.GED or high school diploma; or

B. No GED or high school diploma, employed prior to November 1. 2001 to provide a MH/DD/SA service; and

C. Upon hiring, an individualized supervision plan shall be developed and supervision shall be provided by a qualified professional, or associate professional with the population served.

Only qualified professionals as outlined in the APS-M 45-2, Chapter IV page 9 and Appendix A page 39 may assign a primary diagnosis.

A screening may be conducted by a paraprofessional who has met the competency requirements within their scope of practice to conduct screenings.

38. Would it be permissible for therapeutic foster parents to document on the Service Note log rather than the grid?

Response: No, in accordance with the APS-M 45-2, page 17, a grid must be used to document Day Habilitation, Supported Living, Supported Employment (CAP-MR/DD), Residential Treatment, (Level I); and Residential Treatment-Family Type (Level II). Other services are documented per the sample forms A through E following page 49 in APS-M 45-2. The grid and forms A through E may be modified. All documentation and modifications must follow the requirements in APS-M 45-2 (p. 16 – Contents of a Service Note and Frequency of a Service Note; page 17 Grid – contents of a Grid and page 48 – Instructions on How to use the grid).

39. Is the State going to draft a key/legend to use for the intervention/assessment ranking for CAP documentation?

Response: In accordance with the APS-M 45-2, 9/1/2003, no, each provider agency has the flexibility to develop their own keys based on the documentation requirements in APS-M 45-2 on page 17 – Contents of a Grid and page 48 Instructions on How To Use The Grid.

40. Is the State going to require a narrative note for Respite services and for all paraprofessional services?

Response: In accordance with APS-M 45-2, a narrative or a modified checklist format can be used to document respite.

Refer to page 18 in the APS-M 45-2, Exceptions to the Above Requirements, item #6 and #7, page 31 Modified Consumer Record for documentation requirements. Service notes shall include:

a. The dates(s) of the service and for hourly services the duration of the service event;

b. **Tasks performed including any comments on any behaviors, etc., which are considered relevant to the consumer's continuity of care; documentation that special instructions were followed, etc.; and**
c. **Signature (initials if corresponding full signature included on the page)**